State Employee Medical Services Division

Authorization Form for Release of Records and Information

A. Identification: This document authorizes the use and/or disclosure of confidential protected health information about the following person:

Employee/Applicant Name: _____
Address: _____
_____
Employee/Applicant Date of Birth: _____
Daytime Phone Number: (_____) _____
Employee/Applicant Social Security Number: _____

B. Directions for Release: I authorize the individual or company identified below in Section B.1b to release and/or use protected health information identified in Section B.2 pertaining to the individual listed in Section A to the individual or company identified in Section B.1a.

B.1a. I authorize the disclosure of information to:
State Employee Medical Services Division
State of Maryland Medical Review Officer
Appointing Authority (Identify) _____
For current State Employee, current Appointing Authority _____

B.1b. I authorize the obtaining of information from:
Kroll Laboratory Specialists, Inc.
State of Maryland Medical Review Officer

B.2. Information to be released: I authorize the disclosure and/or use of any information, including medical information, laboratory results and medical opinions, relating to the specimen(s) collected from me on (specify date of collection) _____.

B.3. Purpose: I authorize the disclosure and/or use for employment purposes.

C. Right to Revoke: I understand that I may revoke this Authorization at any time except to the extent that action has already been taken in reliance upon it. If I do not revoke it, this Authorization will expire one (1) year after the date on which the Authorization is signed. To revoke the Authorization, I understand I must contact the following in writing: Margaret Embardino, Director, Employee Medical Services Division, Department of Budget and Management, 301 W. Preston Street, Room 508, Baltimore, MD 21201; or, via Fax to 410-333-5440.

D. Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions in Section B. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by Maryland law which prohibits redisclosure or other laws limiting the use and/or disclosure of my confidential protected health information.

I, _____, have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this form, I am authorizing the use and/or disclosure of my confidential protected health information. I understand, further, that if I refuse to sign this form, I may be subject to disciplinary action up to and including termination from State Service and/or no further consideration for employment.

_____ _____
Your Signature Date

_____
Signature of Witness

White Copy - AGENCY (ATR) · Yellow Copy - EMPLOYEE · Pink Copy - COLLECTION REPRESENTATIVE

(Revised 3/17/05)